HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

Date_____
Time_____
HCP_____
BP_____
Wt_____
Tob Y/N
ppd___yrs__
PRP Y/N
All_____
Meds_____
_____
_____
_____
_____

Family Practice Clinic **31st MDG** **Aviano AB, Italy**

S: ____ yo M/F presents for evaluation of total blood **CHOLESTEROL** level. No h/o heart disease.

Coronary Heart Disease (CHD) Risk Factors **PRIMARY PREVENTION**

Positive Risk Factors (RF)

Y N Male > 45 yo **OR** Female > 55 yo or premature menopause w/o estrogen therapy

Y N Family history of Premature CHD (definite myocardial infarction-heart attack- or sudden death before 55 yo in father or other male 1st degree relative, or before 65 yo of age in mother or other female 1st degree relative.)

Y N Current cigarette smoking

Y N Hypertension (BP > 140/90 or taking antihypertensive medications)

Y N Low HDL (<35 mg/dl)

Y N Diabetes

Negative Risk Factors

Y N High HDL (>60 mg/dl) If Y then subtract one risk factor

O: Total Risk Factors_____ Random nonfasting Total Cholesterol _____, HDL _____on _____.

A/P: ___If Total Chol but no HDL ordered, **ORDER** fasting lipid panel if Chol>200, if <200 no further action

___If Desirable Chol (<200) and HDL > 35 → **Provide** handout for general education and repeat in 5 years.

___ " " and HDL < 35 → **ORDER** fasting lipid panel

___If Borderline-High Chol (200-239) and HDL >35 *and* < 2RF → **Refer** to HAWC and repeat in 1-2 years

___ " " and HDL < 35 *or* 2 or more risk factors → **ORDER** fasting lipid panel

___If High Chol (>240) → **ORDER** fasting lipid panel

(OVER)

ATIENT'S IDENTIFICATION *(Use this space for Mechanical nprint)*

RECORDS MAINTAINED AT: ▶

PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*Sign each entry*)
	Other Risk Factors addressed:
	Results sent by mail on_____
	FOLLOW-UP:
	S/O: Date_____ Fasting lipids: Total Chol _____, Triglycerides_____, HDL _____, LDL _____.
	If LDL is > 130 and two or more RFs or LDL is >160 repeat fasting lipid panel 1-8 wks apart:
	Date_____ Fasting lipids: Total Chol _____, Triglycerides_____, HDL _____, LDL _____.
	Average LDL _____
	A/P/P: ____ If Desirable LDL (< 130) → **Repeat** total Chol with HDL in 5 yr.
	Provide handout for general education
	____ If Borderline-High-Risk LDL (130-159) and <2 RFs → **Provide** Dietary and Exercise consults;
	Repeat in 1-2 years
	____ " and 2 or more RFs → **Schedule** appointment with provider for clinical evaluation;
	order labs*; **Provide** Dietary and Exercise consults
	____ If High-Risk LDL (>160) → **Schedule** appointment with provider for clinical evaluation;
	order labs*; **Provide** Dietary and Exercise Consults
	____ If Triglycerides > 200 and < 400 then counsel patient on weight reduction,alcohol restriction, tobacco
	cessation, control of blood sugars if diabetic, and increased physcial activity. If greater than 400 than refer to
	provider.
	*LABS: TSH, Chem 7, CBC, Liver panel, UA
	PROVIDER NOTES: